PSYCHIATRIC PRACTICE GUIDELINES

SECTION CONTENTS

PSYCHIATRIC PRACTICE GUIDELINES

INTRODUCTION

Development of Guidelines

The following guidelines on Psychiatric Practice within the Forensic Conditional Release Program (CONREP) were developed in 1995-96 by Forensic Services CONREP Operations in cooperation with an Advisory Committee of CONREP provider physicians and DMH administrative, medical, pharmacological and legal consultants. Using the same consensual procedure, they have been updated.

These guidelines do not address aspects of general medical practice. Rather, they provide an overview and guide for physicians who are prescribing, or contemplating prescribing, psychotropic medications as part of the treatment plan for persons on conditional release. They are not intended to be exhaustive or to supplant general standards of community forensic psychiatric practice, but do address key elements of psychiatric practice in the unique CONREP outpatient environment.

Description of Patients

Most persons conditionally released are severely mentally disabled males, 18-44 years of age, with histories of violent crime. As many as two-thirds may have secondary chemical dependency disorders. They typically require exceptional forensic evaluation, supervision and treatment including psychopharmacological treatment, psychotherapy and psychosocial rehabilitation.

Use of Psychotropic Medications

Safety Record

While severe psychiatric illness carries significant risk of mortality, the safety record of psychotropic medications, and the negligible risk of fatal adverse outcomes due to their use, is remarkable. This is especially so when compared with other medications in use.

INTRODUCTION

Use of Psychotropic Medications (cont.)

Part of Treatment Plan	Psychotropic medication, which can be prescribed only by a physician, shall be used as part of an integrated, individualized treatment plan developed by an interdisciplinary team process under the direction of the Community Program Director. This plan may include individual and group therapy. Other modalities such as psycho-social rehabilitation, education or industrial therapies may be used. Patient progress in these programs, however, is most often dependent upon appropriate medication, permitting changes in the patient's disturbed perceptual, behavioral, and/or cognitive symptoms.
Clinical Justification and Documentation	Ethical standards of practice, as well as provisions of law, mandate that medication never be used with mentally disordered patients as punishment, for the convenience of staff, to control behavior which is not a symptom of a diagnosable disorder, or as the only treatment modality. Documentation of the clinical justification for use of psychotropic medication and an ongoing evaluation of its effectiveness are imperative.
Benefit versus Risk	Although these drugs are generally safe, they may have uncomfortable side effects (as distinguished from more medically significant adverse effects) and a potential for serious disability. Physicians, therefore, should utilize all available research, knowledge and clinical expertise in prescribing such medication. Each prescription should be carefully weighed on the basis of benefit expected versus the risk to be incurred, either from the side effects of the medication or the risk incurred by not using medication.

INTRODUCTION

Use of Psychotropic Medications (cont.)

Patient Response	People with a psychiatric illness respond to medication differently than the usual adult population. Patients with developmental disabilities often respond differently than those with mental disabilities. Several factors, such as variation in age, sex, body weight, ethnicity, and metabolism of drugs, as well as the severity and type of mental disorder, must be considered when individualized regimens are designed.
Medication Changes	Once a patient has been stabilized, every effort should be made to establish the lowest effective dose. The hospital treatment regimens have been established over long periods of time. Historical indications of the patient's potential for violent (and in some cases lethal) behavior must be kept in mind. As a result of this special situation, it is recommended that the treating physician carefully evaluate and consider the patient's medication history and present clinical status in determining the need for any possible change of medication.
Use of Other Medications	Other medications for which there are few community-established guidelines, clinical studies, or protocol (off-label use, such as the use of anti-androgens in the treatment of Sex Offenders) may be used with psychopharmacological consultation.

THERAPEUTIC DECISION PROCESS

Physician Responsibility

The physician has the authority and responsibility for making the decision as to choice of medication, route and schedule of administration, dosage and duration, and integration with the total treatment plan.

The physician shall document fully the rationale and indications for medications and prescribe only those medications clearly required to treat serious conditions or prevent further deterioration.

Medication histories elicited from patients, relatives, and former providers of care, including state hospital staff, frequently prove useful. The ethical, legal and civil rights of the patient must also be kept in mind. In making a decision about medication treatment, a physician should take the following factors into consideration.

Factors to Consider

Use of Antiparkinson Agents

Physicians must recognize the possible detrimental effects of continuous use of antiparkinson agents. There is evidence that these agents impair memory, and may cause anticholinergic psychosis. They may also have a strong abuse potential, particularly tri-hexyphenidyl and benztropine.

Akathisia

Akathisia, both subjective and objective, should be recognized as a potential cause of agitation and violence in patients treated with neuroleptics. Consideration should be given to lowering the dose of neuroleptic, changing to one of the newer atypical neuroleptics, or adding a beta blocker, or antiparkinson agent rather than increasing the dose of the neuroleptic when akathisia is suspected or present.

THERAPEUTIC DECISION PROCESS

Factors to Consider (cont.)

Drug Abuse History	Because of the prevalence of substance abuse in the histories of forensic patients and its correlation with violence in this population, physicians should be cautious when prescribing drugs with abuse potential (such as anxiolytic medications, hypnotic agents and stimulants).
Route and timing of Administration	Physicians should also keep in mind that orders which permit oral or intramuscular [IM] routes should reflect the fact that the same dose of neuroleptic given IM may be up to two and one-half (2 1/2) times more potent than when given orally.

Patient Participation

Patient Information	In the course of the initial medication visit, CONREP patients shall be fully informed by the physician of the proposed treatment program. They must be provided with appropriate written and verbal information to enable them to participate in formulating their treatment. To the fullest practical extent, the information provided should include: * The anticipated beneficial outcome; * Possible immediate and/or long term effects of the medication; as well as * Alternative therapies and medications. * Outcome without medications/treatment
Involvement In Decision Making	CONREP patients are under compulsory provisions which result in treatment of their mental disorder on an involuntary basis. To the maximum extent possible in each case, they should be encouraged to participate actively in the therapeutic decision making process, including medications. Whenever possible, they should provide appropriate written or documented verbal assent to the plan of treatment.

THERAPEUTIC DECISION PROCESS

Patient Participation (cont.)

Involvement In Decision Making (cont.)	CONREP patients should agree (with advice of counsel, and the acceptance and approval by the committing court), as one condition of placement on CONREP in the community, to accept prescribed treatment, including medication prescribed by the treating psychiatrist and/or treating physician. If the patient refuses to take prescribed medication (or it is evident that the patient has stopped taking it), an assessment must be done immediately, or as soon as possible, regarding the reason, whether the refusal or noncompliance is reasonable/rational under the circumstances, and whether this development indicates that hospitalization and/or revocation should be initiated. Efforts should be made to arrive at a mutually agreeable treatment plan. Factors for discussion with the patient, in consultation with a psychiatrist, include: has a medical condition been discovered that impacts continuing the medication; are there serious side effects that have emerged from the medication at issue; are there alternative medications or other options that would be effective; and can the patient be better informed of the benefit and the importance of taking the medication for optimal functioning on outpatient.

MEDICATION TERMINOLOGY

Psychotropic Medications

Psychotropic medication is the broad, generic designation for the group of drugs employed in treating mental disorders. This category includes all of the specific medications to be discussed in these guidelines.

Antipsychotic Medications

Antipsychotic drugs are employed in the treatment of major mental disorders, namely psychoses. Currently, the most common antipsychotic agents are the Atypical Antipsychotic Medications, which include Ziprasidone, Clozapine, Olanzapine, Quetiapine and Risperidone.

Typical Antipsychotic medications include the phenothiazine group with its aliphatic, peperidine and piperazine subclasses, the thioxanthenes, the butyrophenones, some dibenzoxazepines, the dihydroindolenes and their derivatives, the diphenylbutylpiperidines, and the benzisoxazoles.

Mood Stabilizing Medications

Lithium

Lithium is a cationic salt useful for the management of acute manic psychosis and certain schizoaffective conditions and as a prophylactic agent in selected bipolar and unipolar depressions and mania.

Carbamazepine

Carbamazepine is a tricyclic anticonvulsant drug sometimes used empirically in the treatment of certain refractory affective psychoses, especially lithium-resistant bipolar illness.

Clonazepam

Clonazepam is a benzodiazepine which is reported to have antimanic and antianxiety properties. This agent is sometimes used as adjunctive treatment for acute manic episodes.

MEDICATION TERMINOLOGY

Mood Stabilizing Medications (cont.)

Valproic Acid	Valproic Acid (Valproate) is an anticonvulsant drug sometimes used as primary or adjunctive treatment of certain symptoms of affective disorders, particularly manic symptoms of bipolar or schizoaffective disorders.
Lamotrigine	Lamotrigine is an anticonvulsant drug that has been used in controlling rapid cycling and mixed bipolar states for those who have not received relief from other anti-manic drugs.
Gabapentin	Gabapentin is an anticonvulsant drug that has been used in the treatment of certain affective disorders.
Antidepressant Medications	The term antidepressant drug is used for those psychotropic medications whose major use is the alleviation of depression. This group of drugs includes the heterocyclic antidepressants, monoamine oxidase (MAO) inhibitors and serotonin reuptake inhibitors (SRIs).
Anxiolytic Medications	The designation anxiolytic drug is used for those psychotropic medications whose primary purpose is the reduction or control of anxiety and agitation. This class includes benzodiazepines, partial serotonin agonists and alprazolam, which may be used for panic disorder.
Sedative/Hypnotic Agents	The term hypnotic agent refers to the class of psychotropic drugs whose primary action is sedation of the central nervous system resulting in relaxation or sleep. This includes certain benzodiazepines, the barbiturates, and chloral hydrate.
Stimulants	This class of psychotropic medications is used for the stimulation of the central nervous system and is prescribed for attention deficit disorder and narcolepsy. This class of compounds includes amphetamines, methylphenidate, pemoline, and chemically related compounds.

MEDICATION TERMINOLOGY

Anticonvulsants	This class of psychotropic medications has the primary action of controlling a seizure disorder. Some of these medications exhibit antimanic properties as well.
Antiparkinson Agents	The broad, generic designation of antiparkinson drugs is for the class of medications used to treat extrapyramidal side effects of neuroleptic medications, including pseudo-parkinsonism, akathisia and dystonia.
Beta Blockers	Beta Blockers are certain beta adrenergic blocking agents occasionally used empirically in treating refractory behavioral aggressive states. Certain beta blockers, particularly propranolol, have also been determined to be useful in treating extra-pyramidal reactions, especially akathisia.
Clonidine	Clonidine is an antihypertensive medication which has been for the treatment of Tourette's Syndrome and autonomic symptoms of opium withdrawal.
Polypharmacy	Some CONREP patients have been effectively treated in state hospitals through the use of multiple psychotropic medications. With the development of new medications in the past 10 years, this is becoming a more common practice. Use of multiple psychiatric medications requires extensive monitoring for possible drug interactions and adverse drug effects.
Use of PRNs	While psychotropic PRN (Pro Re Nata) orders are a part of psychiatric treatment, they are rarely used in the CONREP outpatient population. Use of PRN medications should be based on the prevailing community outpatient treatment standard. Excessive use of PRNs may indicate a clinically unstable patient.

PSYCHOPHARMACOLOGICAL CONSULTATION SYSTEM (CS)

Description

Each CONREP program shall participate in a Psychopharmacological Consultation System (Medication Monitoring/Peer Review) whose primary purpose will be the provision of expert consultation whenever:

* Requested by any physician member of the CONREP program; or
* A plan of treatment has been initiated which includes an exception to the usual psychotropic medication guidelines (herein described).

The priorities and primary responsibilities of the CS system are described below. A more complete description of this system's function and responsibilities shall be contained in each program's policy and procedures.

System Priorities

Each Consultation System shall be responsible for establishing priorities in responding to requests for consultations and to expedite those requests which require an immediate response. Less urgent technical deviations from the guidelines can be given a lower priority and should be accommodated after the urgent issues have been addressed.

CS Responsibilities

Members

The CS system members serving as consultants provide consultation for physician members of the CONREP staff who request consultation.

Mandatory Consultations

Documented consultations are mandatory in the following circumstances:

* The standard upper limit of psychotropic medication is exceeded;

* A neuroleptic or amoxapine is prescribed for a patient with diagnosed tardive dyskinesia, new onset neuroleptic malignant syndrome [NMS] or marked extra-pyramidal symptoms;

PSYCHOPHARMACOLOGICAL CONSULTATION SYSTEM (CS)

CS Responsibilities (cont.)

Mandatory Consultations (cont.)

* A psychotropic agent is prescribed for a pregnant patient;

* A patient receives polypharmacy treatment as defined in these guidelines, subject to the following exceptions:

  a. PRN or stat doses;
  b. the use of amantidine, hydroxyzine, diphenhydramine, and buspirone;
  c. the use of a sedating antidepressant (e.g. a tricyclic antidepressant) in the evening in combination with an activating antidepressant (e.g., a selective serotonin reuptake inhibitor) in the morning;
  d. changing from one neuroleptic to another; and
  e. medication regimens accepted by state hospital Therapeutic Review Committees are acceptable for twelve (12) months after hospital discharge to CONREP, as long as a copy of the TRC consultation is kept in the CONREP medical record.

* A patient is prescribed an androgen depleting/ inhibiting hormone. This is not a routine psychiatric treatment. On the rare occasions when it will be considered, consultation is required to ensure that the patient's consent is a voluntary and informed decision based upon a documented rationale by the physician;

* When ten (10) or more doses of PRN and/or stat medications of the same therapeutic class are administered in a month as part of a stable medication regimen; and

* A patient receives scheduled chronic pain relieving medications for over 30 days or benzodiazepines for over six months. In chronic pain situations, a consultation with the prescribing physician and/or a pain medical specialist is strongly encouraged.

GEROPSYCHIATRY GUIDELINES

Description

The following recommendations apply to any patient who because of advancing age is more likely to be pharmacodynamically compromised, particularly anyone over 65 years of age. Pharmacodynamic changes may appear before age 50 and progress upward.

Prior to Prescribing

Several factors should be addressed prior to prescribing medication for this age group:

* Review the patient's medical and mental status; and
* Consider interactions with other medications.

Low Dosages

Start with low doses and increase gradually, unless patient history dictates otherwise. Starting doses of 1/5 to 1/4 the usual starting doses may be more appropriate, recognizing that 1/3 to 1/2 or less of the usual upper limit may be a likely target dose. Serum levels should be monitored accordingly.

Serum Levels

As clinically indicated, serum levels should be monitored for medication.

Resuming Medications

Some patients may not be able to tolerate doses as prescribed in the past after having had the medication discontinued for a period of time. In such cases, consider resuming the medication at a lower dose and increase it, as tolerated, to the previous level.

Side Effects

Patients should be monitored for orthostasis, dehydration, ataxia and other side effects for which older persons may be particularly susceptible. Also, consider using divided doses to reduce side effects, particularly with those medications which produce orthostatic hypotension.

GEROPSYCHIATRY GUIDELINES

Other Considerations

During Medical Illness	It is important to consider lowering or discontinuing the dose of psychotropic medications during medical illness or surgery.
Extended Half Lives	Consider whether a particular medication has an extended half-life in the elderly patient.
Advanced Age	Consider that as patients advance in age, they may require even lower doses of many medications.

STANDARD PSYCHIATRIC PRACTICE

Admission Note

On admission, each patient should have a note which addresses the following information:

* Diagnosis;
* Signs and symptoms of the disorder;
* Treatment recommendations;
* Any history of drug/alcohol abuse;
* Prior psychiatric hospitalizations;
* Medications prescribed:
  a. Response;
  b. Compliance;
  c. Side effects; and
  d. Changes and rationale;

* Justification for continued medication use, addressing risk/benefit, informed consent and tardive dyskinesia (if pertinent); and

* Patient advisement of the nature of his/her illness, the need for treatment, the proposed treatment plan as well as the risks/benefits of the treatment.

Physician Progress Notes

Pertinent changes shall be documented in any of the following areas:

* Diagnosis;
* Signs and symptoms of the disorder;
* Treatment recommendations; and
* Medications prescribed:
  a. Response;
  b. Compliance;
  c. Side effects; and
  d. Changes and rationale.

STANDARD PSYCHIATRIC PRACTICE

Annual Psychiatric Note

Prior to the Annual Case Review, in preparation for the interdisciplinary team review, the psychiatrist should provide a note which documents:

* Diagnosis;
* Signs and symptoms of the disorder;
* Treatment recommendations;
* Medications prescribed:
  a. Response;
  b. Compliance;
  c. Side effects including tardive dyskinesia assessment (AIMS);
  d. Changes and rationale; and
  e. Progress over the last year.

* Justification for continued medication use addressing risk/benefit and informed consent and tardive dyskinesia (if pertinent); and

* Patient advisement of the nature of his/her illness, the need for treatment, the proposed treatment plan as well as the risks/benefits of the treatment.

Physical Examination

CONREP physicians should have access to and a copy of medical physical examinations conducted on program patients. Where performed by other clinics or agencies (private physicians, residential care home "house doctors," VA physicians or others), a copy of any report/findings should be requested after obtaining a signed release of information from the patient. A copy of any medical information along with a copy of the patient's signed release must be made a part of the CONREP program outpatient file.

Oral Instructions for Medical Care

Where oral instructions are provided for medical care following a medical physical examination, written verification of oral instructions should be obtained and made a part of the CONREP program patient file.

STANDARD PSYCHIATRIC PRACTICE

Prescriptions	The physician should indicate generic names of drugs, dosage, frequency of administration, and refill numbers.
Patient Medication Information	Patients should have access to information about the medications they receive in simple written format.
Laboratory Results	Physicians should order necessary laboratory tests for patients. Physicians should either initial laboratory results and file them in the medical record or enter results in medical notes to verify awareness of the results.
Emergency/Back-Up Coverage	There should be a clear procedure for emergency or vacation back-up for the psychiatrist. This procedure should be contained in the program's policy and procedure manual.

UPPER LIMITS OF USUAL DOSAGE

Summary Information

A *Table of Upper Limits of Usual Dosage* is included at the end of this section. Upper limits are based on those used by state hospitals, rather than the American Psychiatric Association's Committee on Peer Review's outpatient upper limits (which are designed for a broad range of typical outpatients). These upper limits are reflected in the table and are believed appropriate for CONREP patients.

In general, dosages apply to physically healthy adults of average size and should be decreased when applied to children, elderly or adults who are debilitated.

Absolute Upper Limits

Except for thioridazine, there are no absolute upper limits for any medication, but instances of dosages exceeding the recommended upper limit must be referred within the internally established Consultant System.

Conversion Factors

Fluphenazine Decanoate

25mg. of fluphenazine decanoate every 2 weeks is about equal to 10mg./day of the oral formulation. This conversion factor is used when calculating total daily dosage of fluphenazine for patients receiving both oral and injectable forms.

Haloperidol Decanoate

15mg. of haloperidol decanoate every 4 weeks is about equal to 1 mg./day of the oral formulation. This conversion factor is used when calculating total daily dose of haloperidol for patients receiving both oral and injectable forms.

Depo-neuroleptic Medications

Long-acting depo-neuroleptic medications are used only with clinical evidence that the patient cannot tolerate oral administration.

Laboratory Chemistries

Laboratory chemistries are recommended for patients on psychotropic medication as clinically indicated and not less often than once a year. Physicians shall initial or sign the reports before filing in the medical record.

TABLE OF UPPER LIMITS OF USUAL DOSAGE

CALIFORNIA FORENSIC CONDITIONAL RELEASE PROGRAM

Class	Generic Name	Proprietary Name	Upper Limits (mg/24 hrs)
Neuroleptic	Aripiprazole	Abilify	30
	Chlorpromazine	Thorazine; Sonazine	1600
	Clozapine	Clozaril	900
	Fluphenazine Decanoate	Prolixin Decanoate	100/every 2 weeks
	Fluphenazine HCL	Prolixin; Permitil	80
	Haloperidol	Haldol	80
	Haloperidol Decanoate	Haldol Decanoate	450/every 4 weeks
	Haloperidol & Haloperidol Decanoate Combination		80
	Loxapine	Loxitane	250
	Mesoridazine	Serentil	400
	Molindone	Moban	225
	Olanzapine	Zyprexa	30
	Perphenazine	Trilafon	64
	Pimozide	Orap	20
	Quetiapine	Seroquel	800
	Risperidone	Risperdal	10
	Thioridazine	Mellaril	800
	Thiothixene	Navane	100
	Trifluoperazine	Stelazine	60
	Ziprasidone	Geodon	160
Antimanics	Carbamazepine	Tegretol	2000 -blood levels must be titrated
	Clonazepam	Klonopin	20
	Gabapentin	Neurontin	3600
	Lamotrigine	Lamictal	500
	Lithium	Eskalith, Lithobid	2700 -blood levels must be titrated
	Valproic Acid	Depakene, Depakote	4000 -blood levels must be titrated

TABLE OF UPPER LIMITS OF USUAL DOSAGE

CALIFORNIA FORENSIC CONDITIONAL RELEASE PROGRAM

Class	Generic Name	Proprietary Name	Upper Limits (mg/24 hrs)
Heterocyclic Antidepressants			
	Amitriptyline	Elavil, Endep	300
	Amoxapine	Asendin	300
	Bupropion	Wellbutrin	450
	Bupropion sustained release	Wellbutrin SR	400
	Desipramine	Norpramin, Pertofrane	300
	Doxepin	Adapin, Sinequan	300
	Imipramine	Tofranil, Pramine	300
	Maprotiline	Ludiomil	225
	Mirtazapine	Remeron	45
	Nefazodone	Serzone	600
	Nortriptyline	Aventyl, Pamelor	150
	Protriptyline	Triptil, Vivactil	60
	Trazodone	Desyrel	600
	Venlafaxine	Effexor	375
	Venlafaxine extended release	Effexor XR	225
Serotonin Selective Reuptake Inhibitors (SSRIs)			
	Citalopram	Celexa	60
	Fluoxetine	Prozac	80
	Fluvoxamine	Luvox	300
	Paroxetine	Paxil	50
	Sertraline	Zoloft	200
MAO Inhibitors	Isocarboxazid	Marplan	30
	Phenelzine	Nardil	90
	Tranylcypromine	Parnate	60

TABLE OF UPPER LIMITS OF USUAL DOSAGE

CALIFORNIA FORENSIC CONDITIONAL RELEASE PROGRAM

Class	Generic Name	Proprietary Name	Upper Limits (mg/24 hrs)
Anxiolytics	Alprazolam	Xanax	6
	Atomoxetine	Strattera	*1.4mg in children up to 70kg and 100mg/day in children>70kg or more in adults*
	Buspirone	Buspar	60
	Chlorazepate	Tranxene	60
	Chlordiazepoxide	Librium	100
	Diazepam	Valium	60
	Hydroxyzine	Vistaril, Atarax	400
	Lorazepam	Ativan	10
	Oxazepam	Serax	120
Stimulants	Dextroamphetamine	Dexedrine	60
	Dextroamphetamine-amphetamine mixture	Adderal	80
	Methylpenidate	Ritalin	1mg/kg body weight
	Pemoline	Cylert	112.5
Hypnotics	Amobarbital	Amytal (for agitation)	500/dose or 1000/24hr
	Chloral Hydrate	(Various)	2000
	Flurazepam	Dalmane	30
	Temazepam	Restoril	30
	Triazolam	Halcion	0.25
Antiparkinson	Amantadine	Symmetrel	300
	Benztropine	Cogentin	6
	Diphenhydramine	Benadryl	150
	Trihexyphenidyl	Artane	15
	Biperiden	Akineton	6

Reference: California Department of Mental Health State Psychiatric Hospitals Psychotropic Medication Guidelines and the Clozapine Protocol. This document was developed by the Statewide Psychopharmacology Advisory Committee effective July 14, 2003.